

VIRGINIA DEPARTMENT OF HEALTH

**MANAGING ACCOUNTS RECEIVABLE
FOR PATIENT CARE**

February 2005

Managing Accounts Receivable for Patient Care

Introduction

This document outlines the procedures to be applied to effectively and equitably manage accounts receivable for patients receiving medical services and supplies at VDH health districts. The procedures are applicable to chargeable services in all programs, including Family Planning (which, until now, has operated under somewhat different procedures).

Clients of the Virginia Department of Health shall not be denied service or subjected to any variation in quality of service due to *inability* to pay. The agency's eligibility determination process has been designed to take the patient's ability to pay into account. Depending on income and applying annual federal poverty income guidelines, the agency determines whether the client should not be charged a fee (income level A) or whether the client is able to pay some percentage of the cost on a sliding scale, up to 100% (income levels B-G).

Once *ability* to pay is determined by applying the federal guidelines, if a patient in income levels B through G *refuses* to pay (after counseling, billing and reasonable warning), service shall be denied, because the effect of non-payment by a client who is able to pay is to unfairly divert limited funds for services from other citizens needing care. It is also unfair to all other patients in levels B through G who are willing and do pay their "fair share" fee charges. The use of payment plans to stretch out payments and the use of waivers for good medical or financial reasons are additional mechanisms designed to make the process as fair and reasonable as possible.

Procedures

To the extent possible, patients in one of income levels B through G should be advised of the charges they will encounter and their payment responsibility at the time an appointment is made for their visit. A patient in one of income levels B through G who does not pay for the services, tests or supplies at the time of the visit will be offered financial counseling, including the following information:

- Clients are expected to pay for the services, tests and supplies during the visit or, if unable to pay during the visit, within 30 days of the date of the visit;
- The client has an opportunity to agree to a payment plan, permitting payments to be made in installments over a period of months;
- State policy requires that delinquent accounts be referred to the Department of Taxation for debt set-off and to private agencies for collection;

- Non-payment will be cause for denial of future services, tests and supplies, unless a waiver of payment for the new services is approved as described below:
 - If the client experiences a serious personal or family financial emergency, the client may request a waiver of payments for **new** services, tests and supplies. The health department may waive all or a portion of such payments for up to 180 days (a “financial waiver”).
 - If the client has unusually serious health problems, the health department may waive all or a portion of payments for **new** services, tests and supplies for up to 180 days (a “medical waiver”).
 - If the patient is receiving on-going medical care and a waiver has not been granted, the department will make a good faith effort to find alternative care.

The patient will be asked to sign a form documenting this counseling. (Note: This information can be included in an existing consent form. A sample of a new form is attached.)

A patient shall not be denied future services, tests and supplies unless this financial counseling has been provided.

- Throughout the billing and collection process, patient contact and confidentiality requirements will be appropriately considered and addressed.
- On the date of service, the patient will be provided a detailed statement of charges for the services, tests and supplies and will be expected to pay the balance owed within thirty days of the date the services, tests or supplies were provided, or in accordance with the terms of a payment plan.
- Bills to patients will include a statement to the effect that non-payment of the balance or any portion thereof may be cause for denial of future services and that delinquent accounts will be referred to the Department of Taxation for debt set-off and to private collection agencies.
- If the patient fails to make the payment(s) as scheduled, the patient will be sent a “delinquent” bill with a notice that a refusal to pay the amount due, plus a late charge, will be cause for denial of future services, tests and supplies or that payment for future services will be required in advance. The notice will urge the patient to contact the health department where service was provided to discuss the matter with someone in the business office.
 - This discussion could form the basis for a new eligibility determination, applying the most recent federal poverty income guidelines and/or a waiver

by the District Health Director of all or a portion of new charges for up to 180 days. This notice will be documented in the patient's record.

- VDH staff should also be alert to situations in which a waiver for medical reasons may be appropriate (e.g., a pregnant patient in a high risk category), whether or not the patient requests such a waiver. The health director shall be informed of such situations before services are denied.
- If the client makes a partial payment of an amount due, the health department will recognize it as a good faith effort to pay and will suspend the initiation of debt set-off or collection actions until the next billing cycle.
- If the overdue payment is not made within the next 30 days, the account will be referred to the Department of Taxation for debt set-off and to private collection agencies and it will be written off in accordance with standard procedures.

Denial of Service

If a patient has refused to pay and the account has gone through the sequence described above, further services, tests and supplies shall be provided only under the following circumstances:

- Clients with overdue bills are eligible for non-chargeable services and may not be denied such services.
- For all other services, a new eligibility determination will be made, applying the latest federal poverty income guidelines. If the patient does not provide the necessary documentation, the new services, tests or supplies will be denied.
- If the eligibility determination establishes the patient is at level A, the services, test and supplies will be rendered.
- If the eligibility review determines that the patient is at level B through G, the services, test, and supplies will be denied. Alternatively, at the option of the health director, or his/her designee, the patient shall be required to pay for new services, tests and supplies in advance of receiving them.

Two sample financial agreements are attached, to be used as part of the financial counseling described above. One is for use when a patient is expected to pay the entire balance within 30 days. The other is for use when the patient elects to execute a payment plan, with installments paid over a period of months. As a separate project, the contents of the sample agreement will be integrated with other VDH consent forms executed by patients or their guarantors. Until new forms are developed, the samples may be used.

**VIRGINIA DEPARTMENT OF HEALTH
FINANCIAL AGREEMENT**

Patient Name: _____

Patient ID: _____

I, _____, agree to pay \$_____ for services, tests and supplies provided by the Virginia Department of Health to me or my dependant as named above, on _____. I understand that I must pay the charges in full within 30 days, unless a special installment payment plan has been approved permitting me to make partial payments over a period of months. If a payment plan is approved, I agree to make the monthly payments as specified in that plan. The Department of Health will bill me for the outstanding charges. However, if I don't receive a bill, I understand that it is my responsibility to pay the amount that is due.

I understand that I am responsible for paying each bill when it is due and I agree to make the payments. If payments are not made when they are due, I understand and agree that the VDH may require payment of the total amount owed in the account. *I understand and agree that a late fee of 10% of the total amount of the debt will be assessed for accounts that are delinquent. I understand and agree that delinquent accounts will be transferred to private collection agencies or the Office of the Attorney General for intensive collection efforts; and will also be sent to the Department of Taxation where the amount owed to VDH will be deducted from any of my tax refunds or lottery winnings. I understand and agree that additional fees will be charged to my account to cover the costs of these actions.*

I understand and agree that if my account is delinquent, VDH may deny me or my dependant, as named above, further supplies and services or may require that I pay for supplies and services at the time of the visit.

However, if my failure to make the required payments is due to an extraordinary personal or family financial hardship or if I or my dependent, as named above, experience unusually serious health problems, I may request approval of a temporary waiver of charges for new supplies and services and I agree to provide whatever documentation may be needed to verify the impact of the financial emergency. If VDH authorizes a temporary waiver, the waiver will be in writing and the new supplies and services will be provided without charge or at reduced charge. No VDH employee is authorized to waive payments without an approved, written waiver, signed by an authorized official.

If I or my dependant, as named above, have been receiving ongoing care for a medical condition at the health department, the health department will make a good faith effort to find alternative care, before denying my dependant or me continued service.

I certify that the information I have provided is a true and complete statement according to my best knowledge and belief, and that a full explanation of services and charges has been given to me. I understand that if I give false information, withhold information or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued.

Signature of patient, parent, legal guardian or person acting in Loco Parentis

Date signed

Relationship

Signature of Person Obtaining Consent

**VIRGINIA DEPARTMENT OF HEALTH
APPLICATION FOR PAYMENT PLAN**

Patient Name: _____ **Patient ID:** _____

I, _____, request that an installment payment plan be established in my name for the purpose of paying my outstanding balance for supplies and services provided to me or my dependant, as named above, by the Virginia Department of Health (VDH), an agency of the Commonwealth of Virginia. I understand that if my application is approved, an account will be established in my name to track the amount I owe to VDH, payments I have made, new charges for supplies or service I or my dependant named above have received, late fees, the balance remaining in the account and the minimum installment payment that I must pay to keep the account current. The Department of Health will bill me for the installment amounts. However, if I don't receive a bill, I understand that it is my responsibility to pay the amount that is due.

I am responsible for paying each bill when it is due and I agree to make the payments. If installment payments are not made when they are due, I understand and agree that the VDH may require payment of the total amount owed in the account. *I understand and agree that a late fee of 10% of the total amount of the debt will be assessed for accounts that are delinquent. I understand and agree that delinquent accounts will be transferred to private collection agencies or the Office of the Attorney General for intensive collection efforts; and will also be sent to the Department of Taxation where the amount owed to VDH will be deducted from any of my tax refunds or lottery winnings. I understand and agree that additional fees will be charged to my account to cover the costs of these actions.*

I understand and agree that if my account is delinquent, VDH may deny me or my dependant further supplies and services or may require that I pay for supplies and services at the time of the visit.

If my failure to make the required payments is due to an extraordinary personal or family financial hardship or if I or my dependant, as named above, experience unusually serious health problems, I may request approval of a temporary waiver of charges for new supplies and services and I agree to provide whatever documentation may be needed to verify the impact of the financial emergency. If VDH authorizes a temporary waiver, the waiver will be in writing and the new supplies and services will be provided without charge or at reduced charge. No VDH employee is authorized to waive payments without an approved, written waiver, signed by an authorized official.

If my dependant or I, as named above, have been receiving ongoing care for a medical condition at the health department, the health department will make a good faith effort to find alternative care before denying me or my dependant continued service.

I certify that the information I have provided is a true and complete statement according to my best knowledge and belief, and that a full explanation of services and charges has been given to me. I understand that if I give false information, withhold information or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued.

Signature of patient, parent, legal guardian or person acting in Loco Parentis

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Signature of Person Obtaining Consent